DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 2761-99
12 May 2000

[redacted]

Dear [redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 11 May 2000. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the advisory opinion furnished by Specialty Advisor for Neurology dated 14 March 2000, a copy of which is attached.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained in the advisory opinion. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official

records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

5830
14 Mar 00

From: CDR D. M. E. Llewellyn, MC, USN
Specialty Advisor for Neurology
To: Chairman, Board for Corrections of Naval Records

Subj: REQUEST FOR COMMENTS AND RECOMMENDATION IN THE CASE OF [redacted]

Ref: (a) Ltr JRE:jdh Docket No: 2761-99 dtd 21 January 2000
(b) Medical and Service Records

1. In response to reference (a), the medical and service records (reference (b)) of 1stLT Wade P. Bettis have been reviewed. The former service member requests that his naval records be corrected such that his discharge in 1946 be changed to Medical retirement. He contends that he already suffered from Multiple Sclerosis (MS) when he was discharged. His records have been thoroughly reviewed. There is no support for his contention from the medical records provided. There is some evidence that he had headaches prior to discharge. Otherwise, there is no evidence of any neurological disease until 1950. It is very clear that Mr. Bettis is disabled, but I see no evidence to support a diagnosis of MS prior to his discharge. In fact, the diagnosis is not definitive, and may be cerebrovascular disease. Finally, I have never examined Mr. Bettis, and it is difficult to put myself in the place of a physician 50 years ago. Both of these issues are limitations.

2. Review of his Military Medical records revealed:

9/24/45 – examination - no mention or evidence of neurological disease.

2/8/46 – "Examined this date and found physically qualified for release from active duty..... Requires neither treatment nor hospitalization."

3/7/46 – "relieved from active duty". Pay problems.

6/5/47 – Letter from Mr. Bettis stating that it is impossible to attend active training because of work/harvest conflicts. No mention of medical problems.

3. His recent medical records refer to a diagnosis of MS in 1947. However, the reviewed records indicate onset of symptoms in 1950. Attention is directed to his VA records for current symptoms which include: cognitive dysfunction, depression, right sided weakness and sensory disturbance, nystagmus, and bladder dysfunction. These clearly can be MS, but they could also be vascular, degenerative, or of mixed etiology. The fact that he was treated for many years with steroids (Medrol and ACTH) is evidence that his physician believed he had MS.

4. There is no definitive diagnostic test for MS. Classically, well before 1950, the diagnosis has been based on multiple neurological lesions disseminated over time and space. He suffered an acute neurological event in 1950, which may have been an "attack" of MS. However, other explanations are possible. Today we support the diagnosis with MRI and spinal fluid testing. Mr. Bettis has no documentation of an MRI. He has had spinal fluid testing; there are no documented abnormalities.

5. The following are germane points from his VA medical records:

2/1990 – Pulmonary embolus s/p Right total hip arthroplasty

7/9/87 – Urology Spastic neurogenic bladder

10/14/87 - Detrussor spasms with sphincter contraction possibly secondary to MS.

9/23/87 – "Neuro exam described a stable MS patient". Only first page available of Neurologist's evaluation. Of note "NO INO". (Internuclear ophthalmoplegia – a lesion in the medial longitudinal fasciculus. This is the locus thought to be responsible for his problems in 1950).

6/2/87 – Orthopedic compensation and Pension review exam - Worsening 2 years previously

5/6/86 – "MS Dx 1947, repeat evaluation 1949 thought Dx was ? Had second Dx in 1950 and Dx was confirmed..... multiple exacerbations over the years with difficulty with bladder ...and with legs" Weakness R > L. Bilateral Babinski's. Referral to Physical medicine and rehab.

12/16/86 - "in March of 1986 my physical condition began to deteriorate rather rapidly; and my disabilities that have plagued me for many years have increased..." Worsened when stopped Medrol.

9/8/86 – Ophtho. "This has, by history, involved the eyes, though I find no evidence today on examination." "He denies a frank amaurosis typical of optic neuritis."

6/16/86 – Ophtho: "normal dilated fundus exam." "Optic nerves looked excellent on both eyes with no evidence of Multiple Sclerosis involvement"

11/27/70 – Neuro: "Probable MS", "currently on hormone therapy"

9/25/70 – Neuro: "Right hemiparesis about the same"

Subj: REQUEST FOR COMMENTS AND RECOMMENDATION IN THE CASE OF FORMER [redacted]

11/9/70 – Attorney's letter: "...it was determined that he did have multiple sclerosis and that the original diagnosis made in 1950 was correct". " .... and has so suffered from the year 1950"

7/22/70 – 7/28/70 - Hospitalized for evaluation of "difficulty in walking times twenty years. This man's problems began in 1950 when he had diplopia and complete ophthalmoplegia and right hemiparalysis". Exam showed right sided weakness, increased DTRs on the right with a Babinski sign on the right. Laboratory testing included a spinal tap. "Cell count was 3 RBCs and 2 WBCs. Report of the protein and sugar is not back yet. Especially we are interested in the immunoelectrophoresis of the spinal fluid. This is not back yet". Brain scan was done which was within normal limits as was the EEG". "History most compatible with MS".

9/30/70 – "Rating Decision": "MS was first diagnosed at VAH, Portland in 1950. SC was denied in 1952 as there was no evidence of the disability during service or within the prevailing presumptive period. Vet reopened his claim in 196(?)2 but failed to report for scheduled exam and the claim was abandoned".

8/10/70 – "Statement in support of claim" by Mr. Bettis: "Please reopen my claim to establish an MS or vascular disorder condition as service connected. This claim had been initiated some time ago but was not pursued to completion" . ('or vascular disorder' is hand written in above typed statement.)

3/24/70 – Neurology consult: "In my opinion, the neurological problems are related to an intracerebral problem, which has not yet been defined, and probably won't be until we do an angiography, or brain scan and/or both". ..."however, it is a little bit obscure as to exactly what is going on. The history of weakness of the right leg, the dragging of the leg, goes back to 1965. I would certainly not make a diagnosis of multiple sclerosis at this or any other time on the basis of this symptom. I feel that he should be further investigated before we commit him to a diagnosis."

11/3/61 – "Reference is made to your recent neurological examination of October 27, 1961, at this hospital. As a result of this examination it was the recommendation....that the established clinical diagnosis...Multiple sclerosis, be changed to 'Neurological Disease, type undetermined". "Your examination of October 27, 1961, also indicated that at the present time there is no evidence of a neurological disease of any type."

10/27/61 – "This patient at the age of 27 yrs was admitted... on 2-4-50, with the chief complaint of blurring vision, diplopia, fixation of the eyes. He could not open his mouth, or hold his head up. There was numbness over the left side. There was unsteadiness in his gait. After two weeks the patient began to notice improvement in his complaints". ..."During the 12-year interval from the patient's hospitalization in February of 1950 there is no history of neurological dysfunction. The neurological examination of October

27, 1961, was within normal limits. I would recommend that the diagnosis of multiple sclerosis in 1950 be changed to...."

9/14/51 – "Rating sheet" - Reference to "splitting headaches" during service. Affidavit of wife of 8/51 reporting headaches even while on leave, his stubborn refusal to admit sickness of any kind, and continuity of headaches". Other affidavits attesting to headaches.

"Headaches, shown to have occurred during service are claimed to be indicative of inception of disease. The evidence, however, indicates a plausable and even more likely reason.. wearing of sound powered phones"

2/4/50 – 2/21/50 - Narrative Summary of hospitalization written 2/21/50 : History of headaches back to 1942. Onset of neurological condition with "difficulty focusing eyes when shaving" on 1/30/50. 2/3/50 noted flattening of left face. Difficulty expectorating. Inability to see to right or left with driving. ROS: During interval from D/C from service to 1950 "no lost time from work due to illness". Exam: "facial palsy on the left" "lateral conjugate deviation of the eyes to either right or left was absent". "Convergence was still present." "All other findings below the neck were absolutely normal." (?pupils. Assumption that DTRs normal). LP reported with normal pressure, normal protein, glucose and 2 lymphocytes. EEG abnormal for slowing diffusely. Diagnoses considered: "multiple sclerosis or a vascular accident" "Felt that the most likely diagnosis was MS". Localized to midline lesion...involving bilateral medial longitudinal fasiculi.

6. It is clear from the evidence that his neurological problems started in 1950. It appears as if he did well until the 1960's or 1970. His headaches were probably present prior to his release from active service. However, headaches are not a typical feature of MS. In summary, it is clear that Mr. Bettis has a debilitation neurological condition. The exact diagnosis can be argued. The 1950 attack was probably central, but it may have been a peripheral nervous system disorder such as an acute polyneuritis. However, it is clear that the documented first neurological event was 1950. If this supports Mr. Bettis' claim, so much the better.

D. M. E. LLEWELLYN